

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1411

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Virginia COUNTY					
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Perry Point LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Arlington (If rural, give location)					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		1806 N. Mayne Street					
3. NAME OF DECEASED (Type or Print)		(First) WILLIAM (Middle) N.M. (Last) ALLEN	4. DATE OF DEATH February 8 1951								
5. SEX	Male	6. COLOR OR RACE	White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	Married	8. DATE OF BIRTH	April 10, 1907	9. AGE last birthday	43 yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Tele. Repairman		10b. KIND OF BUSINESS OR INDUSTRY		Telephone Company		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
								West Virginia		USA	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.II		17. INFORMANT AND ADDRESS		Hospital Records, VAH, Perry Point, Md.					
18. MEDICAL CERTIFICATION											
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
Immediate cause		(a) Coronary Thrombosis due to									
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Coronary Sclerosis, severe									
		(c) Arteriosclerosis, generalized									
2 hrs. INTERVAL BETWEEN ONSET AND DEATH											
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION									
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) OF INJURY		(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work m. Not While At work	HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 12, 1951, to Feb. 8, 1951, and last saw the deceased alive on Jan. 20, 1951, and that death occurred at 3:10 AM m., from the causes and on the date stated above.											
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED					
E. P. BRANNON, M.D.		Chief, Professional Services, VAH, Perry Point, Md.		2-8-51							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)			
Removal		2-8-51		Unknown		Arlington, Virginia					
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS					
Feb 8, 1951		Dene E. Daugherty, Pennington & Son, Havre de Grace, Md.				690367					



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1412

Reg. Dist. No.... 92

1. PLACE OF DEATH. CITY Cecil			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Md.		
TOWN Elkton			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun, Md.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Reed	(Last) Andrew	4. DATE OF DEATH	(Month) Feb. (Day) 5 (Year) 1951
5. SEX	6. COLOR OR RACE Male White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Dec. 16, 1873	9. AGE last birthday 77 yrs.	If under 1 year Months Days Hours [Min.]
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Gardener & Carpenter	11. BIRTHPLACE (State or foreign country) Perryville Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Andrew			14. MOTHER'S MAIDEN NAME Frances Riddle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 219-01-0711A		17. INFORMANT Mrs. Myrtle Acton	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
451x Immediate cause (a) <i>cardio nephritis</i>				
131a Antecedent cause(s) (b) <i>Thrombosis of Iliac arteries</i>				
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?
21. ACCIDENT (Specify) SUICIDE HOMICIDE			PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
m.				

22. I hereby certify that I attended the deceased from <i>Jan 24, 1951</i> , to <i>Feb 4, 1951</i> , that I last saw the deceased alive on <i>Feb 4, 1951</i> , and that death occurred at <i>9:15 A.M.</i> , from the causes and on the date stated above.				
SIGNATURE <i>Alfred Dodson Jr.</i>	(Degree or title) <i>Resident</i>	ADDRESS <i>Rising Sun Md.</i>	DATE SIGNED <i>Feb 6 1951</i>	

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 7, 1951	NAME OF CEMETERY OR CREMATORIAL West Nottingham	LOCATION (City, town, or county) Near Colora, Md.	(State)
DATE REG'D BY LOCAL REG. <i>Feb 6</i>	REGISTRAR'S SIGNATURE <i>H. Frayser</i>	24. FUNERAL DIRECTOR ADDRESS <i>J. E. Tyson, Rising Sun, Md.</i>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

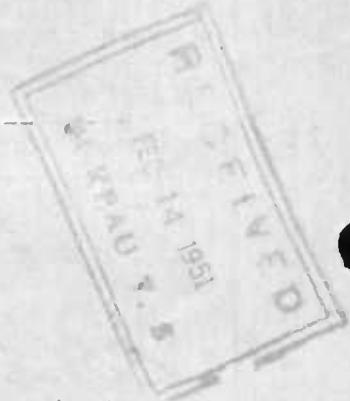
2411 N. Charles Street, Baltimore

1413

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Washington, D. C.			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Perry Point		LENGTH OF STAY (in this place) 13 days			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington			
3. NAME OF DECEASED (First) OLIVER		4. DATE (Month) February			
(Middle) A.		(Day) 8			
(Last) BARNES		(Year) 1951			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 24, 1910		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab Driver	10b. KIND OF BUSINESS OR INDUSTRY Private	9. AGE last birthday 40 yrs.	If under 1 year Months Days Hours Min.		
11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME George H. Barnes	14. MOTHER'S MAIDEN NAME Glennie D. Exum				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH 4 days		
Immediate cause 200.2		(a) Uremia, Uremic poisoning due to			
Antecedent cause(s) 552 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Malignant Lymphoma, thoracic			
		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Jan. 26, 1951, to Feb. 8, 1951, that I saw the deceased above on _____, 19_____, and that death occurred at 11:35 AM m., from the causes and on the date stated above. SIGNATURE: (Degree or title) ADDRESS DATE SIGNED <i>Braun</i> P. P. BRAUN, M.D.					
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-19-51	NAME OF CEMETERY OR CREMATORIAL Church Cemetery	LOCATION (City, town, or county) Washington, D.C.	(State)	
DATE REC'D BY LOCAL REG.	REGISTRATION'S SIGNATURE Diana E. Langford	FUNERAL DIRECTOR L. E. Murray	ADDRESS L. E. Murray & Son, 1327 10th St. N.W. Wash. D.C. 682536		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1414

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil

County Elkton

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, Institution, or street address where death occurred:

139 Collins St.

How long in hospital or institution?

3. (a) FULL NAME

Isola Bartonothus

4. Sex

Female

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Gaddius Bartonothus

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct. 11, 1893

8. AGE: Year

57

Month

4

Days

If less than one day

hre.

min.

9. Birthplace

Elkton, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

own home

12. Name

Levi Tilghman

13. Birthplace

Elkton Maryland

14. Maiden name

Susie Wilson

15. Birthplace

Elkton Maryland

16. Informant

Helen L. Dennis

Address

710 N. DeKalb St., Phila. Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Providence Cem.

Cemetery or crematory

Elkton, Maryland

Location

Isola R. Bell

18. Funeral director

909 Poplar St., Wilm. Del.

Address

Feb. 10, 1951

19. (Date rec'd by registrar)

H. Frazer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md. County

Elkton

(If outside city or town limits, write RURAL and give nearest town)

139 Collins St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 5 1951 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 10, 1950 to February 5, 1951

and that I last saw her alive on February 4, 1951

Immediate cause of death

Cardiac insufficiency

DURATION

14 days

Due to

Due to

Other conditions

421.1 Large heart

92a (Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

James L. Johnson, M.D.

Address

Elkton, Md.

Date signed 2/10/51



MARGIN RESERVED FOR BINDING

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is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1415

Reg. Dist. No. 92

FILE NO. G 130 FEB 14 1951

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
COUNTY

Berlil
Eaton
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS
Elmwood Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE*Bd.*
Cecil

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
. TOWN
STREET
ADDRESS
Elmwood
(If rural, give location)

3. NAME OF DECEASED
(Type or Print)

(First) *Charles* (Middle) *Jesse* (Last) *Boseman* | 4. DATE OF DEATH *2 - 2* (Month) *1951* (Day) (Year)

5. SEX

M. 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED
(Specify) *Sing.* | 8. DATE OF BIRTH *1-31-51* 9. AGE last birthday If under 1 year
yrs. | If under 24 hrs.
Moths. | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) *Eaton Md.* | 12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME

Joseph Charles Boseman | 14. MOTHER'S MAIDEN NAME *Helen Virginia Van Den Heuvel*

15. WAS DECREASER EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO.

No | — | 17. INFORMANT AND ADDRESS *Helen V. Van Den Heuvel*

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH *Pneumonia and septicemia (2/13/51)* | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) *Infection due to 48 hour*

Antecedent cause(s)

(b) *labor infection of mother*
mother Came into hospital with 102°.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT (Specify)
SUICIDE
HOMICIDE

PLACE (Home, farm, factory, street, of office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?
OF INJURY	m.			While at Work	Not While At work

22. I hereby certify that I attended the deceased from *1-31*, 19*51*, to *2 - 2*, 19*51*, that I last saw the deceased

alive on *2 - 1*, 19*51*, and that death occurred at *1.30 a.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE *2-3-51* NAME OF CEMETERY OR CREMATORIAL *Methodist* LOCATION (City, town, or county) *Cherry Hill Cecil* (State) *MD*

DATE REC'D BY LOCAL REG.

REG. *Feb 3* REGISTRAR'S SIGNATURE *F.H. Frazer* 24. FUNERAL DIRECTOR *Joseph A. Evans* ADDRESS *Elmwood North East Md.*

201311201408





Charles H. Demond

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1417

CERTIFICATE OF DEATH

Reg. Dist. No....

94

1. PLACE OF DEATH-
CITY
OR
TOWN

Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY
(in this place)

TOWN

North East

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Lightfoot

3. NAME OF
DECEASED
(Type or Print)

CHARLES H DEMOND

(First) (Middle) (Last)

4. DATE
OF
DEATH

(Month) (Day) (Year)

2 23 51

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify)

Widow

8. DATE OF BIRTH

Sep 17 1861

9. AGE last birthday

88 yrs.

If under 1 year
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Coal Road Walker

10b. KIND OF BUSINESS OR
INDUSTRY

At 19 yrs

11. BIRTHPLACE (State or foreign country)

North East MD

12. CITIZEN OF WHAT
COUNTRY

USA

13. FATHER'S NAME

Joseph H. Demond

14. MOTHER'S MAIDEN NAME

Caroline Bullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Edna Cameron

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442x

Immediate cause

(a)

Antecedent cause(s)

61

Diseases or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(b)

61

Hypertensive Arteriosclerotic Cardiovascular Neural Disease

5 years

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not

related to the disease or condition causing death.

Diabetes Mellitus

260X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

12. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
of office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

INJURY OCCURRED

While at Work

Not While At work

m.

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes

No

DATE SIGNED

ADDRESS

1. I hereby certify that I attended the deceased from

May 1946, to Feb 1951, that I last saw the deceased

alive on Feb 1951, and that death occurred at

7:10 P.m., from the causes and on the date stated above.

(Degree or title)

ADDRESS

2. SIGNATURE

Klaus H. Hubner

M.D.

North East Md

26 Feb '51

VS. A15

1. BURIAL, CREMATION
REMOVAL (Specify)

Burial

DATE

2-27-51

NAME OF CEMETERY OR CREMATORIAL

Melbodust

LOCATION (City, town, or county)

North East

(State)

2. DATE REC'D BY LOCAL REG. 2-27-51

REG. 2-27-51

REGISTRAR'S SIGNATURE

Joseph R. Shady

North East

ADDRESS

785506

785506

THE CORRECT PAGE
IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1418

Reg. Dist. No. 92

CERTIFICATE OF DEATH

1. PLACE OF DEATH- CITY TOWN		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- CITY TOWN		COUNTY		
Cecil Elkton		Length of Stay (in this place)		Maryland Elk Mills		Cecil		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Union Hospital		STREET ADDRESS		(If rural, give location)		
3. NAME OF DECEASED (Type or Print)		(First) CatherYN	(Middle)	(Last) Dempsey	4. DATE OF DEATH	(Month) Feb	(Day) 4	(Year) 1951
5. SEX F		6. COLOR OR RACE W.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Oct 22, 1900		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Grove, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Dempsey		14. MOTHER'S MAIDEN NAME Grace Chadwick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		
17. INFORMANT AND ADDRESS William Dempsey								

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.
is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Bronchial Pneumonia				3 days
Antecedent cause(s) 1190				
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 1190		Infectious Diarrhea		24 hrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Feb., 1951, to 4 Feb., 1951, that I last saw the deceased

alive on 3 Feb., 1951, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE George J. Knecht Jr.

(Degree or title)

ADDRESS Elkton, Md.

DATE SIGNED 2-4-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 2-6-51	NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery	LOCATION (City, town, or county) (State) Elkton, Md.
DATE REC'D BY LOCAL REG. Feb 5		REGISTRAR'S SIGNATURE J. H. Trahan		24. FUNERAL DIRECTOR J. W. Pippin, Jr. Elkton, Md.
ADDRESS				
20-2-04-1-17-2-40-8				



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1419

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Cecil MARYLAND		District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
Veterans Administration Hospital		1123 Congress Street, S.E.	
3. NAME OF DECEASED (Type or Print)	(First) CONRAD	(Middle) D.	(Last) ERNST
4. DATE OF DEATH	(Month) February	(Day) 11	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH
Male	White		June 21, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Private	Missouri	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Conrad B. Ernst	Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
Yes		Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Uremia, Uremic poisoning due to			
446 X Antecedent cause(s) (b) Nephrosclerosis Severe Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last due to			
131a (c) Arteriosclerosis generalized, severe			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia, left lower lobe			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour)		INJURY	(COUNTY)
OF INJURY		While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
VA 22. I hereby certify that I attended the deceased from 10-12, 1948, to 2-11, 1951, that I last saw the deceased Signature, and that death occurred at 6:45 P.M., from the causes and on the date stated above. (Degree or title) ADDRESS DATE SIGNED			
B. P. Brannon, M.D. Chief, Professional Services, VAH, Perry Point, Md. 2-12-51			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)
Removal	2-12-51		(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
Feb. 12, 1951	Dean E. Daugherty Pennington & Sons		Havre de Grace, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1421
Reg. Dist. No. 92

1. PLACE OF DEATH CITY COUNTY Cecil.		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY Maryland Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chesapeake City, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital		STREET ADDRESS (If rural give location) Biddle St.	
3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) E.	(Last) Foard
4. DATE OF DEATH Feb. 4/51	(Month) 19	(Day)	(Year)
5. SEX F.	6. COLOR OR RACE Wh.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Sept. 25/76
9. AGE last birthday 74 yrs.	10. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Eli J. Foard	14. MOTHER'S MAIDEN NAME Mary E. Billary		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Miss Fannie Foard	Chesapeake City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Acute Cardiac dilatation*INTERVAL BETWEEN
ONSET AND DEATH
10 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last(b) *Coronary thrombosis**2 wks*(c) *Cardio renal vascular disease*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year)	(Hour) White at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	INJURY OCCURRED Not White	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Feb. 2*, 1950, to *Feb. 4*, 1951, that I last saw the deceasedalive on *Feb. 3*, 1951, and that death occurred at *2 A.M.* from the causes and on the date stated above.SIGNATURE *Herbert Bates*(Degree or title) *M.D.*ADDRESS *Elkton Md.*DATE SIGNED *2/4/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF Feb. 7/51	NAME OF CEMETERY OR CREMATORIAL Bethel	LOCATION (City, town, or county) Near Chesapeake City, Md.	(State)
--	------------------------	--	--	---------

DATE REC'D BY LOCAL REG. <i>Feb. 6</i>	REGISTRAR'S SIGNATURE <i>F.H. Frazer</i>	FUNERAL DIRECTOR <i>Holifield & Sons, Elkton Md.</i>	ADDRESS
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1421

94

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHARLESTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHARLESTOWN</u>	
LENGTH OF STAY (In this place) <u>30</u>		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u>	(Middle)	(Last) <u>FREDERICK</u>
4. SEX <u>MALE</u>	5. COLOR OR RACE <u>WHITE</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	7. DATE OF BIRTH <u>3-22-1859</u>
8. AGE last birthday <u>91</u> yrs.	9. IF under 1 year Months	10. IF under 24 hrs. Days	11. If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATED MACHINESHOP RET 30 yrs</u>		11. BIRTHPLACE (State or foreign country) <u>BOSTON CHESTER NY USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CARL FREDERICK</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen Frederick</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>			
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Name, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> m.	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>46</u> , to <u>Feb</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>18 Feb</u> , 19 <u>51</u> , and that death occurred at <u>9:45 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Max H Fischer</u>		(Degree or title) <u>M.D.</u> ADDRESS <u>North East Rd</u> DATE SIGNED <u>19 Feb '51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2-20-51</u> NAME OF CEMETERY OR CREMATORIAL <u>RIVERVIEW</u> LOCATION (City, town, or county) <u>WILMINGTON</u> (State) <u>Md</u>	
DATE RECD BY LOCAL REG. <u>2-19-51</u>		REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u> FUNERAL DIRECTOR <u>Joseph R. Grant</u> ADDRESS <u>North East Rd</u> <u>690 368</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

14295

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Cecil</i> Rising Sun Rural MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Md.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun Rural	
LENGTH OF STAY (in this place) 72 yrs.		(If rural, give location) STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Franklin	(Last) Garvin
4. DATE OF DEATH	Feb. 16	(Month) 1951	(Day) 10
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify if widow)	8. DATE OF BIRTH
Male	White		Sept. 4, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<i>Farmer</i>	<i>Own Farm</i>	<i>Rising Sun Md. Rural</i>	<i>U.S.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Benjamin Garvin</i>	<i>Susan Ferguson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
no		<i>Mrs. Elwood Biggers</i>	<i>Rising Sun, Md.</i>
18. MEDICAL CERTIFICATION			
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>331x Immediate cause (a) <i>Cerebral Hemorrhage</i> 18 days</p> <p>832 Antecedent cause(s) (b) <i>Arterio - Sclerosis -</i> 10 yrs</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <i>Hypertension -</i> 10 yrs</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?			
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 19, 1951, to Feb 16, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 4:45 P.M.; from the causes and on the date stated above.			
SIGNATURE <i>B. Ferguson, M.D.</i>	(Degree or title) ADDRESS	DATE SIGNED Feb 19, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 20, 1951	NAME OF CEMETERY OR CREMATORIAL Brookview	LOCATION (City, town, or county) Rising Sun, Md. (State)
DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE Feb. 19, 1951	24. FUNERAL DIRECTOR J. E. Lyon ADDRESS Rising Sun, Md. 290116		



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1423

CERTIFICATE OF DEATH

Reg. Dist. No.

95

1. PLACE OF DEATH-

COUNTY Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL and
OR give nearest town) LENGTH OF STAY
TOWN Rising Sun Rural (in this place)
25 yrs.HOSPITAL OR
INSTITUTION OR
STREET ADDRESS2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md.

COUNTY Cecil

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Rising Sun Rural
STREET
ADDRESS (If rural, give location)3. NAME OF
DECEASED
(Type or Print)(First)
Mildred(Middle)
Eliza(Last)
Graybeal4. DATE
(Month) (Day) (Year)
OF
DEATH Feb. 18 1951

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widowed

8. DATE OF BIRTH

9. AGE last birthday

If under 1 year
Months Days Hours Min.

Oct. 13, 1889 61 yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY U.S.

13. FATHER'S NAME

Own Home

14. MOTHER'S MAIDEN NAME

Reeves COX

Eliza Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

Winton Graybeal Rising Sun, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

15 minutes

Antecedent cause(s)

(b)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

Virus Pneumonia

Hours

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY

m.

INJURY OCCURRED
While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1951, to Feb. 18, 1951, that I last saw the deceased

alive on Feb. 18, 1951, and that death occurred at 4:30 p.m., from the causes and on the date stated above.
SIGNATURE ADDRESS DATE SIGNED23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)
Md.

Feb. 22, 1951

West Nottingham

Near Colora,

DATE REC'D. BY LOCAL
REG. OFFICE

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 19, 1951

Lynn Nottingham

L. C. Lyon Rising Sun Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1424

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY - Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE - Md COUNTY - Cecil	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN - Chesapeake		LENGTH OF STAY (in this place) 33 yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chesapeake City		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN - Chesapeake City STREET ADDRESS - Md	
3. NAME OF DECEASED (Type or Print)	(First) Harry	(Middle)	(Last) Hernick
4. SEX M	5. COLOR OR RACE wh.	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	7. DATE OF BIRTH Feb 4, 1910
8. AGE last birthday 41 yrs.	9. IF under 1 year Months. Days	10. IF under 24 hrs. Hours	11. If over 1 year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Worker		10b. KIND OF BUSINESS OR INDUSTRY - Auctioneers	
11. BIRTHPLACE (State or foreign country) Glen Lyon Pa.		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Nicholas Hernick		14. MOTHER'S MAIDEN NAME Pauline Hernick Sr.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mary Hernick Ches City Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
5 minutes

Antecedent cause(s)

Cardiac decompensation

3 months

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Valvular stenotic heart disease

35 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR? Not While At work
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Feb 12, 1951, to Feb 28, 1951, that I last saw the deceased

alive on Feb 27, 1951, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED
3/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE Mar 3/51	NAME OF CEMETERY OR CREMATORIAL St. Rose's	LOCATION (City, town, or county) Chesapeake City	(State)
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DATE REC'D BY LOCAL REG.	REG. NO. 100-105	REGISTRAR'S SIGNATURE Mrs. Ralph H. Bell	24. FUNERAL DIRECTOR Hartleyson & Son Elton, Md	ADDRESS
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1425

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY Cecil			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Perry Point			LENGTH OF STAY (in this place) 25 yrs 6 mos 21 days		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Hospital			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		
3. NAME OF DECEASED (First) LOUIS			STREET ADDRESS 7004 Park Heights Avenue		
(Middle) K.			(Last) KLINE		
4. DATE OF DEATH February 1	(Month) February	(Day) 1	(Year) 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 16, 1888	9. AGE last birthday 62	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10b. KIND OF BUSINESS OR INDUSTRY Private	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Mayer Kline - Deceased			14. MOTHER'S MAIDEN NAME Name Unknown - Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I			16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH*4201*
Immediate cause(a) **Coronary thrombosis**

Unknown

Antecedent cause(s)

Coronary sclerosis, severe

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last(b) **Arteriosclerosis, generalized**94a
(c)

Dementia Praecox, Paranoid type

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **12-10, 1925**, to **2-1-, 1951**, ~~and discharged the deceased~~*VA*
and that death occurred at **6:20** am., from the causes and on the date stated above.
SIGNATURE *John E. Brannon, M.D.* (Degree or title) ADDRESS DATE SIGNED

E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. 2-2-51

23. BURIAL, CREMATION
REMOVAL (Specify)
RemovalDATE THEREOF
2-5-51NAME OF CEMETERY OR CREMATORIAL
Baltimore National Cemetery, Baltimore, Md.LOCATION (City, town, or county)
(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

REG DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 5, 1951 *Devere E. Daugherty* *Pennington & Son* *590656*

PENNINGTON & SON, Havre de Grace, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1426

Reg. Dist. No. 92

1. PLACE OF DEATH: CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
<i>Levittown</i>		MARYLAND <i>Levittown</i> <i>124 Millburn St.</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>MARGARETT EMMA MATTHEWS</i>		d 9 1967	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH
<i>F. Col.</i>	<i>Brunette</i>	<i>Married</i>	<i>7-27-1930</i>
10a. USUAL OCCUPATION (Give kind of work done during period of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Waitress</i>		<i>Any Point Inn</i>	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
<i>Frank Williams</i>		<i>Ellston Ind.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT			
<i>Roy Matthews</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Lacerated liver dome.
5 inches in length. Central
concussion injured kidney
fractured ribs.*

819.5 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause
170c stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
<i>2-6-51</i>	<i>opening of abdomen. Lacerated liver.</i>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, etc.) <i>front of house 279.</i>	(CITY OR TOWN) (COUNTY) (STATE) <i>Elston Rural Ind</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Auto. hit concrete abutment</i>
<i>2 6 51 07 12 30 AM</i>		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>2/13/51</i>	<i>Croswell Cemetery</i>	<i>Elston Ind.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Feb 13</i>	<i>J K Frazer</i>	<i>John R Bell</i>	<i>Wil Dela</i>
			<i>730869</i>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1427

96

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Pennsylvania	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wampum	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) H.	(Last) MC CUMMINS
4. DATE OF DEATH February '51	(Month) February	(Day) 19	(Year) 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 2, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James McCummins - Deceased	14. MOTHER'S MAIDEN NAME Olena McCummins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. MM-I	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
421.4	Immediate cause Acute Bacterial Endocarditis	INTERVAL BETWEEN ONSET AND DEATH 12 days	
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Calciferous Valvular Disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour) OF INJURY	(Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from Nov. 29, 1932, to Feb. 7, 1951, and I last saw the deceased alive on Nov. 29, 1932, and that death occurred at 3:45 A.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <i>D. P. Brannon, M.D.</i>			
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-7-51	NAME OF CEMETERY OR CREMATORIAL Unknown	LOCATION (City, town, or county) (State) New Castle, Pa.
DATE REC'D BY LOCAL REG	REG	REGISTRAR'S SIGNATURE <i>Domen E. Daugherty, Pennsylvania</i>	ADDRESS
Feb. 7, 1951			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1428

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Rural</i>		LENGTH OF STAY (in this place) <i>5 yrs.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elkton R.D. 5 Md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Elkton Rural</i>	
		STREET ADDRESS <i>R.D. 5</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>WILLIAM</i>	(Middle) <i>JACOB</i>	(Last) <i>Muller, Sr.</i>
4. SEX <i>M</i>	5. COLOR OR RACE <i>wh.</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	7. DATE OF BIRTH <i>Aug 22 1874</i>
8. DATE OF DEATH <i>Feb 23 1951</i>	9. AGE last birthday 96 yrs.	10. IF under 1 year Months. Days	11. If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School teacher</i>		11. BIRTHPLACE (State or foreign country) <i>Philadelphia Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. INFORMANT AND ADDRESS <i>Mr. Howard Muller, Elkton R.D. 5 Md</i>	
14. FATHER'S NAME <i>Christian Muller.</i>		15. MOTHER'S MAIDEN NAME <i>No.ong.</i>	
16. SOCIAL SECURITY NO.		17. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH I. Immediate cause <i>Malignant Hypertension</i> 445X Antecedent cause(s) <i>Arteriosclerosis</i> 77 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Bilateral Glaucoma</i>		3 yrs + 3 yrs +	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12 Nov., 1948, to 23 Feb., 1951, that I last saw the deceased alive on 21 Feb., 1951, and that death occurred at 1:20 A.m., from the causes and on the date stated above. SIGNATURE <i>George Jones, Jr. M.D.</i> ADDRESS <i>Elkton, Md.</i> DATE SIGNED <i>2-23-51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>Feb 26/51</i> NAME OF CEMETERY OR CREMATORIAL <i>Arlington</i> LOCATION (City, town, or county) <i>Chesapeake</i> (State) <i>MD</i>	
DATE REC'D BY LOCAL REG. <i>Feb 23</i>		REGISTRAR'S SIGNATURE <i>JFKrazer</i> 24. FUNERAL DIRECTOR ADDRESS <i>Blowipp & Son Elkton Md</i>	



DECEASED PERSON'S NAME **AGE**
DATE OF DEATH

DEATH CERTIFICATE
Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1429

Reg. Dist. No.....⁹⁶

1. PLACE OF DEATH- COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		Perry Point 14 yr. 5 mo. 5 days		TOWN		Onancock.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		(If rural, give location)	
						R.F.D. #1, Box 163	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
ROBERT		O.		PADDY		February 23 195	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.		8. DATE OF BIRTH	
Male		Negro		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk.		9. AGE last birthday	
10b. KIND OF BUSINESS OR INDUSTRY		unk.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Unknown		Virginia		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		Yes W-1		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
				Unknown		Viola R. Paddy	
				17. INFORMANT AND ADDRESS		Hospital Records, VAH, Perry Point Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

956 X Immediate cause (a) Peritonitis, diffuse, chemical due to

-3 days

129 Antecedent cause(s) _____ due to _____
Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last _____

(c) Arteriosclerosis, generalized

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION**

| 20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE		(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
			INJURY			
TIME (Month) OF INJURY		(Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		
		m.				

22. I hereby certify that ~~I~~^{V.A.} attended the deceased from July 28, 1937, to Feb. 23, 1951, that I last saw the deceased

~~RECEIVED~~ and that death occurred at 11:45 a.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. S. ELLS, M.D. Act'g. Chief Professional Services, VAH Perry Point Md. 2/23/57

23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORIAL SERVICES, WHETHER PROFESSIONAL OR DOMESTIC
REMOVAL (Specify) (State)

DATE REC'D BY LOCAL REG. **REG.** REGISTRAR'S SIGNATURE **R. S. P. 1-1** 24 FUNERAL DIRECTOR **P. B. C. & J. R.** ADDRESS **Asbury, Va.**

7-24-1957 Irene E Dougherty Vernon Verm



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1430

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
LENGTH OF STAY (in this place) 12yr. 5mo. 5days		STREET ADDRESS 512-12th St., N.E.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) H.	(Last) PERKINS
4. DATE OF DEATH	(Month) February	(Day) 22	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH June 1, 1890
9. AGE last birthday yrs. 60	10. KIND OF BUSINESS OR INDUSTRY Private	11. BIRTHPLACE (State or foreign country) New Hampshire	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker	10b. KIND OF BUSINESS OR INDUSTRY Private	11. BIRTHPLACE (State or foreign country) New Hampshire	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. WV I	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
611	Immediate cause Pneumonia bronchial, bilateral due to	INTERVAL BETWEEN ONSET AND DEATH	
107	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Pylonephritis bilateral		
	(a) _____ (b) _____ (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Abscess multiple prostatic	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) INJURY	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN) HOW DID INJURY OCCUR?
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(CITY OR TOWN) ADDRESS	(COUNTY) DATE SIGNED
22. I hereby certify that I attended the deceased from Sept. 27, 1939, to Feb. 22, 1951, VA , and that death occurred at 6:00 a.m., from the causes and on the date stated above. SIGNATURE E. J. Brannon, M. D. Degree or title Chief, Professional Services, VAH, Perry Point, Md. DATE SIGNED 2-23-51			
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-23-51	NAME OF CEMETERY OR CREMATORIAL Baltimore National	LOCATION (City, town, or county) Baltimore, Md. (State)
DATE REC'D BY LOCAL REG. Feb. 23, 1951	REGISTRAR'S SIGNATURE Irene E. Daugherty, Pennington & Son	GENERAL DIRECTOR PENNINGTON & SON	ADDRESS Havre de Grace, Md. 690-78

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1431

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
Cecil				Md		Cecil	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		(If rural give location)	
rural		12 yrs.		Elkton Rd		Glasgow Road	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)	First	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frieda		Ransauer	Feb.	14	1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	If under 1 Min. Hours
Female	white	Married	Mar 23 1891	59	yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
apron		Industry		Germany Switzerland		US	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
John Ned		Moore					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No				Dr. Leonard Ransauer			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

416x Immediate cause (a) Acute Coronary Occlusion 1st.
 95b Antecedent cause(s) (b) Rheumatic Heart Disease 15 yrs.
 Diseases or conditions, if any, giving rise to the above cause (c) stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none.

20. AUTOPSY?

Yes No

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
		TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 9, 1951, to Feb. 17, 1951, that I last saw the deceased alive on Feb. 13, 1951, and that death occurred at 10:10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	Feb 17 51	Albin Mooreland & Elkton Rd		
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH CITY OR TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
COUNTY Cecil.		STATE Md.	
MARYLAND		COUNTY Cecil.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
CHELSEA CITY P.D. Cecil.		CHELSEA CITY P.D. Cecil.	
3. NAME OF DECEASED (Type or Print)	(First) Harry	(Middle) McKey	(Last) Roberts
4. DATE OF DEATH	(Month) Feb. 25	(Day) 1951	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
M.	Wh.	Widowed.	Oct 15, 1878
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
72 yrs.	SUPERVISOR	Cecil Co. Md.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Thomas Roberts.	Laura Davis.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. MEDICAL CERTIFICATION
Yes		Mr. James Roberts, Ches. City, Md.	Acute Cardiac Dilatation 4 hrs.
No			Arterio venous fistula 2 mos.
Unknown			Cerebral embolism 1 yr.
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.2 93d	(a)	more	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)	
		(c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)
TIME (Month) OF INJURY	(Day) (Year) m.	INJURY OCCURRED While at Work	(CITY OR TOWN) (COUNTY)
INJURY	(Hour) m.	Not While At work	(STATE)
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15th</u> , 1951, to <u>Feb 25th</u> , 1951, that I last saw the deceased alive on <u>Feb 23, 1951</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<i>Jane J. Murphy M.D.</i>		<i>100 W. Main St., Elkhorn, 1942</i>	<i>2/2/51</i>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIY	LOCATION (City, town, or county) (State)
Burial	Feb 25/51	Bethel	Chester City P.D. Md
DATE REC'D BY LOCAL REG.	REG.	REG.	REG.
24. FUNERAL DIRECTOR	ADDRESS		
<i>John Ballou, H. Pitts Phillips & Son</i>	<i>Elkton, Md</i>		
<i>Sept 8, 1951</i>			
<i>930746</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1438
q.v.

CERTIFICATE OF DEATH

Reg. Dist. No....

1. PLACE OF DEATH: CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cecil		COUNTY Md Cecil	
3. NAME OF DECEASED (Type or Print)		(First) Walter	(Middle)	(Last) Rothwell	4. DATE OF DEATH Feb 9 1951
5. SEX M	6. COLOR OR RACE Wh. Fr.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH June 1, 1923	9. AGE last birthday 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton Maryland	
some textile		Textile worker.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Lillian Rothwell	
John		Lillian		Mrs Lillian Weibert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-1537		17. INFORMANT	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Rheumatic Heart Disease				9 yrs.
Antecedent cause(s)				
Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last (c)		None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
—		—		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	HOW DID INJURY OCCUR?
—		m.		—
22. I hereby certify that I attended the deceased from Nov. 11, 1950, to Feb. 9, 1951, that I last saw the deceased alive on Feb. 9, 1951, and that death occurred at 6 a.m., from the causes and on the date stated above.				
SIGNATURE	(Degree or title)		ADDRESS	DATE SIGNED
Dr. W. H. Becker Jr. Elkton Feb. 9, 1951				
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
Burial	Feb 11, 1951	Elkton Cemetery	Elkton	Md.
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 10		E.K. Frazer	H.W. Coffindolan	Elkton Md.
007439				



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1434

Reg. Dist. No. 95

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Liberty Grove		LENGTH OF STAY (in this place) 53 Yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Lula	(Middle) Pusey	(Last) Rowland
4. DATE OF DEATH	Feb. 8	(Month) (Day)	(Year) 51
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH
Female	White		Oct. 5 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Own Home	Port Deposit Md.	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Lewis D. Pusey	Addaliza Knight		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y/N, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
		Wessels Pusey Colora, Md. R.D.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 331x	(a) Cerebral Hemorrhage Parapysis R.t. Side.		
Antecedent cause(s) 83a	(b) Arterio - Sclerosis Hyper Tension -		
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last stating the underlying cause last	(c)		
INTERVAL BETWEEN ONSET AND DEATH 9 days			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 29, 1951, to Feb 7, 1951, that I last saw the deceased alive on Feb 7, 1951, and that death occurred at 6 A.M. from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED B. Johnson, M.D. Port Deposit, Md. 2/9/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 11, 1951	NAME OF CEMETERY OR CREMATORIAL West Nottingham	LOCATION (City, town, or county) Near Colora (State) Md.
DATE REC'D BY LOCAL REC'D 2/9/51	REGISTRAR'S SIGNATURE Lynn Nottingham	24. FUNERAL DIRECTOR J. E. Tyson	ADDRESS Rialto Dr. n. w.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1435

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH. COUNTY Cecil			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit , Rural		
LENGTH OF STAY (in this place) Life			STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED (Type or Print)	(First) Minerva	(Middle) V.	(Last) Rutter	4. DATE OF DEATH Feb. 27, 1951	(Month) (Day) (Year) 19
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1-16-1870	9. AGE last birthday 81	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Maryland		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George A. Lynch			14. MOTHER'S MAIDEN NAME Lenora Benjamin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 17. INFORMANT AND ADDRESS Mrs Edwin Williams, Port Deposit, md		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1/22/2 Immediate cause

(a)

Chronic Myosarclites.

93d Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

*Pulmonary Congestion*INTERVAL BETWEEN
ONSET AND DEATH

5 yrs

3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **Nov-20, 1950**, to **Feb 27, 1951**, that I last saw the deceasedalive on **Feb 27, 1951**, and that death occurred at **4 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

B. Johnson, M.D. 2/28/51.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3-2-1951	NAME OF CEMETERY OR CREMATORIAL Hopewell	LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
DATE REC'D BY LOCAL REG. 74.08.1951	REGISTRAR'S SIGNATURE <i>Jane & daughter</i>	24. FUNERAL DIRECTOR <i>Lia A. Patterson & Son</i>	ADDRESS Perryville, Md.



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1436
Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Perry Point		LENGTH OF STAY (in this place) 22 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS 307 T. Street, N.W.		(If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) JESSE		(Middle) P.		(Last) SHANKLE		4. DATE OF DEATH February 15	(Month) 1951 (Year)
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 8, 1908	9. AGE last birthday 42 yrs.	If under 1 year Months 8	If under 24 hrs. Days 8	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Private	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Shankle - Deceased		14. MOTHER'S MAIDEN NAME Annie Goiro - Deceased					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

48 hours

581.0 Immediate cause (a) Bronchial pneumonia, bilateral

due to

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

(b) Cirrhosis of the liver

(c) Anasarca

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

20. AUTOPSY?

 Yes No

(STATE)

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

--

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(CITY OR TOWN)

(COUNTY)

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) (Year) (Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan. 24, 1951, to Feb. 15, 1951, xbar I last saw the deceased

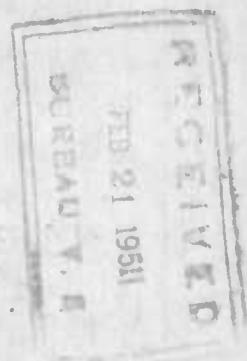
Xbar I last saw the deceased, and that death occurred at 10:35 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-16-51	NAME OF CEMETERY OR CREMATORIAL Arlington National	LOCATION (City, town, or county) Fort Myer, Virginia	(State)
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE Dene E. Daugherty	24. FUNERAL DIRECTOR ADDRESS PINNINGTON & SONS, Havre de Grace, Md.	REG.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No.

94

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS (If rural give location)	
TOWN <u>North East</u>		50 yrs		TOWN <u>North East</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print) <u>Robert H.</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>2 1 1951</u>		(Month) (Day) (Year)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-28-1872</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Sipp</u>				14. MOTHER'S MAIDEN NAME <u>no information</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-5361</u>		17. INFORMANT <u>Mrs Bessie M. Sipp</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442x Immediate cause		(a) <u>Pulmonary Edema</u>					
131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Hypertensive Cardiovascular Renal Disease</u>					
		(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>46</u> , to <u>1 Feb</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1 Feb</u> , 19 <u>51</u> , and that death occurred at <u>11:15 P.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James H. Fletcher M.D.</u>		(Degree or title)		ADDRESS <u>North East, Md.</u>		DATE SIGNED <u>2 Feb '51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-6-1951</u>		NAME OF CEMETERY OR CREMATORIAL <u>Methodist</u>		LOCATION (City, town, or county) (State) <u>North East, Cecil Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-4-51</u>		REGISTRAR'S SIGNATURE <u>Sarah E. Rothamel</u>		24. FUNERAL DIRECTOR <u>Joseph R. Grant</u>		ADDRESS <u>North East, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY CECIL		2. USUAL RESIDENCE (HOME) OF DECEASED STATE NEW JERSEY COUNTY ATLANTIC	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN PERRY POINT,		LENGTH OF STAY (in this place) 7 MOS. 9 DAYS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS 116 S. MASSACHUSETTS AVENUE.	
3. NAME OF DECEASED (First) WILLIAM (Type or Print)	(Middle) H.	(Last) SPAVD	4. DATE OF DEATH February 24 (Month) (Day) (Year) 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 4-10-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (State or foreign country) PALMYRA, NEW JERSEY
13. FATHER'S NAME GEORGE W. SPAVD		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-I	17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH
Unknown

Immediate cause (a) Coronary Thrombosis.

Antecedent cause(s) (b) Coronary Sclerosis

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last
(c) Arteriosclerosis, general.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? m. Not While

22. I hereby certify that I attended the deceased from June 15, 1950., to Feb. 24, 1951., that I last saw the deceased

APPROXIMATELY 10:00 AM, and that death occurred at 1:15 AM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	DATE THEREOF 2/26/51	NAME OF CEMETERY OR CREMATORIAL Beverly National Cemetery	LOCATION (City, town, or county) Beverly, New Jersey	(State)
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DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Dene E. Daugherty	24. FUNERAL DIRECTOR PENNINGTON & SON, Havre De Grace, Maryland
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1439

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
<i>Baltimore</i>		MARYLAND <i>Md.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>JAMES</i>		(Last) <i>2 16 1951</i>	
(First) <i>White</i>		(Month) (Day) (Year)	
6. COLOR OR RACE		7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify)	
<i>White</i>		<i>Single</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Student</i>		<i>Maryland</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Maryland</i>		<i>Maryland</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Oscar Stanley</i>		<i>Martha Estep</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)			
17. INFORMANT			
<i>Martha Stanley</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

<i>780.2</i>	Immediate cause (a) <i>Convulsions</i>	
<i>87e</i>	Antecedent cause(s) (b) <i>cause undetermined</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not white work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb. 19/51</i>	<i>Gulper Morin Pk</i>	<i>Elkton, Md</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<i>Feb. 19</i>	<i>H. Fraser</i>	<i>Swapp & Son</i>	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1440

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY <i>Berl</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Pa.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Enroute to Hosp.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Philadelphia</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ecktor</i>		STREET ADDRESS <i>665 N. 47 St.</i>	

3. NAME OF DECEASED (Type or Print)	(First) <i>MAMIE</i>	(Middle)	(Last) <i>STREETS</i>	4. DATE OF DEATH <i>2. 8 1951</i>
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5. SEX <i>F.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <i>MARRIED</i>	8. DATE OF BIRTH <i>July 25-1896</i>	9. AGE last birthday <i>64 yrs.</i>	If under 1 year Months Days	If under 24 hrs. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Bookkeeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Family</i>	11. BIRTHPLACE (State or foreign country) <i>King & Queen Co. Va.</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i> .
--	---	--	--

13. FATHER'S NAME <i>Edwldlyn. Hill</i>	14. MOTHER'S MAIDEN NAME <i>Mattie Holmes</i>
--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Eleanor Hill Gleaser.</i>
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18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Acute Coronary Thrombosis</i>			

4201 Immediate cause <i>94a</i>	(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>94a</i>	(b)	(c)
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11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
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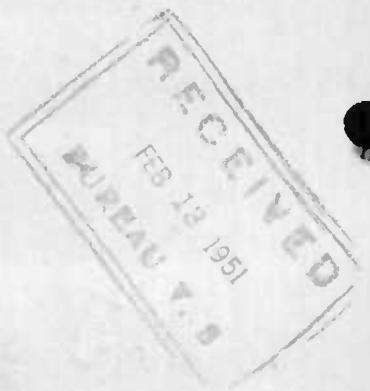
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
--	--	--	--	--

SIGNATURE DATE SIGNED
R. E. Dockson M.D. D.M.E. Dec 9 1951

23. BURIAL, CREMATION REMOVAL (Specify) <i>removal</i>	DATE THEREOF <i>Feb 8</i>	NAME OF CEMETERY OR CREMATORIUM <i>Bethelam Cemetery King & Queen Co. Va.</i>	LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <i>Feb 8</i>	REGISTRAR'S SIGNATURE <i>JFK Frazer</i>	24. FUNERAL DIRECTOR <i>H. W. Pippin</i>	ADDRESS <i>Ecktor, Md.</i>
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1441

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH
CITY (If outside corporate limits, write RURAL and give nearest town)

C.S.C.I.L.

MARYLAND

TOWN North East LENGTH OF STAY
(in this place) 75 yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED
(First)
(Type or Print)

SUSANNA

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE

Md

C.S.C.I.L.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN North East
(If rural give location)STREET
ADDRESS4. DATE
OF
DEATH

2 18 1951

5. SEX

FEMALE

WHITE

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

SINGLE

8. DATE OF BIRTH

Aug 18 1875

9. AGE last birthday

75

yrs.

If under 1 year
Months Days Hours
If under 24 hrs.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

North East Md

12. CITIZEN OF WHAT
COUNTRY

U.S.A.

13. FATHER'S NAME

Eli S. Strimel

14. MOTHER'S MAIDEN NAME

Susan Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Herman Throckmorton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

420.1 Immediate cause

(a) Coronary Thrombosis

12 hrs.

131a Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) Hypertensive Cardiovascular Renal Disease

10 years.

(c) Hypertrophic Arthritis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT
SUICIDE
HOMICIDE
(Specify)PLACE (Home, farm, factory, street,
of office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
White at Not White
m. Work At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to Feb., 1951, that I last saw the deceased

alive on 18 Feb., 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.
SIGNATURE ADDRESS DATE SIGNED

Klaus H Throckmorton

M.D.

North East Md

19 Feb '51

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG. 2-19-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sarah C. Rothermel

Joseph R. Grant North East Md

VVVVVV



11
Evidence for change
in 9 shown on:
The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Form No. G 130 FEB 19 1951

CERTIFICATE OF DEATH

1442
Reg. Dist. No. 96

1. PLACE OF DEATH. COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Washington, D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 1231 Kearny St., N.E. Washington, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print)		(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
Male		Albert Colored	SUMNER	Feb. 10	1951
6. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday If under 1 year Months Days Hours Min.
Male		Colored	Sep	6-5-1909	84 yrs. 8 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unknown		Unknown		Washington, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY USA	
Unknown		Mrs. Ada Sumner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

445x Immediate cause (a)..... Malignant Hypertension 3yr 1Mo 20D

Antecedent cause(s)

102 Diseases or conditions, if any, (b)
giving rise to the above cause
stating the underlying cause last
(c)II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

VA
22. I hereby certify that I attended the deceased from 12-21, 1948, to 2-10 P.M., 1951, that I last saw the deceased
alive on 2-10 P.M., 1951 and that death occurred at 7:50 PM m., from the causes and on the date stated above.
SIGNATURE E.O. P. ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Removal	2-11-51	Mount Hope Cemetery	Washington, D.C.	
DATE REC'D BY LOCAL REG.	REG. 2-11-51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		Irene E. Dougherty	Montgomery (Bro)	913 Florida Ave., N.W. Washington, D.C.

Montgomery Bros. L.P. montgomery vvvvvv



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1443

Reg. Dist. No. 95

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
<i>Baltimore</i> MARYLAND		<i>Pa.</i> <i>Chester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<i>Hornsville & mo.</i>		<i>Kennett Square</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<i>303 S Union</i>			
3. NAME OF DECEASED (Type or Print)	(First) <i>Editliz</i>	(Middle) <i>Douglas</i>	(Last) <i>Swift</i>
4. DATE OF DEATH	(Month) <i>2</i>	(Day) <i>3</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE <i>F</i> <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>7-18-1852</i>
9. AGE last birthday yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Pa</i>	12. CITIZEN OF WHAT COUNTRY <i>W. Germany</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Woman</i>	10b. KIND OF BUSINESS OR INDUSTRY	14. MOTHER'S MAIDEN NAME <i>Wadele Beotters</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mae Kiser</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Myocarditis</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>R. LeDodon</i>	(Degree or title) <i>None</i>	ADDRESS <i>Parney Sun Rd.</i>	DATE SIGNED <i>2/6-51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Feb. 6, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Oxford Cemetery</i>	LOCATION (City, town, or county) (State) <i>Oxford, Chester Co. Pa.</i>
DATE REG'D BY LOCAL REG. CO.	REGISTRAR'S SIGNATURE <i>Z. M. Washington</i>	24. FUNERAL DIRECTOR <i>Ralph J. Reed</i>	ADDRESS <i>Reed Funeral</i>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1444

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County..... Blue Ball Rural-Elkton, Md.
 City or town.....
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs.
 Hospital, institution, or street address where death occurred: Blue Ball
 How long in hospital or institution?

3. (a) FULL NAME
 Elijah Williams

4. Sex Male	5. Color or race Col.	6.(a) Single, married, widowed, or divorced Married
Jennive Williams		

6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo. day, yr.) July 15, 1893
 6.(c) If alive, give age 57 yrs years

8. AGE: Years 57 Months 7 Days If less than one day hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)
 Farm Work

10. Usual occupation..... Moore Rest Home
 11. Industry or business..... Elijah Williams

MOTHER FATHER
 12. Name..... Md.
 13. Birthplace..... Laura

14. Maiden name.....
 15. Birthplace..... Md.

16. Informant..... Jennive Williams
 Address..... Elkton Md. R.5 (Blue Ball)

17. Burial Date thereof..... Feb. 28, 1951
 (Burial, cremation, or removal, Which?) Trinity Cem. (month) (day) (year)

Cemetery or crematory..... Zion Maryland
 Location.....

18. Funeral director..... Edgar R Bell
 Address..... 909 Poplar St., Wilm. Del.

19. Date rec'd by registrar..... Feb. 28, 1951
 (Date rec'd by registrar) H. Frazer
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Md. County..... Cecil
 Elkton (rural)
 City or town.....
(If outside city or town limits, write RURAL and give nearest town)
 Street No..... Blue Ball (rural)
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 23 1951 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 1951 in Feb. 23 1951 and that I last saw him alive on Feb. 22 1951

Immediate cause of death..... Influenza pneumonia. DURATION 5 day

Due to..... Bronchitis

Due to.....

Other conditions..... Cardiac. Gastro.

4900 Gestus
 108 (Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

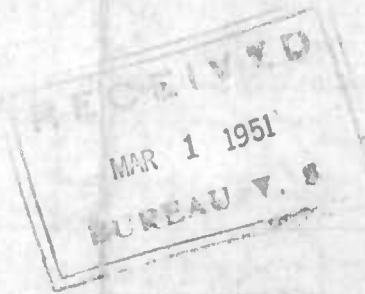
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... James L Johnson M.D. M. D. or other

Address..... Elkton, Md. Date signed 2/26/51

970 868



MARYLAND STATE DEPARTMENT OF HEALTH

1445

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Jodrey</i>		(Month) <i>Feb</i> (Day) <i>13</i> (Year) <i>1951</i>	
(Middle) <i>Newman</i>			
(Last) <i>Wyatt</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>white</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>		8. DATE OF BIRTH <i>Feb. 13/51</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>jeweler</i>		9. AGE last birthday If under 1 year yrs. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Elkton, Md</i>	
13. FATHER'S NAME <i>Jack Wyatt</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Jack Wyatt. 317 Curtis Ave.</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATHImmediate cause *Failure of Closure of Forever Vault*(a) *Failure of Closure of Forever Vault*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last(b) *None*(c) *None*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2 - 13 - 51</i> <i>5:45</i>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <i>None</i>					

22. I hereby certify that I attended the deceased from *2-13-51*, 19*51*, to *2-13-*, 19*51*, that I last saw the deceasedalive on *1-13-51*, and that death occurred at *5:15 p.m.*, from the causes and on the date stated above.SIGNATURE *Jack Newman* (Degree or title) ADDRESS *Elkton, Md* DATE SIGNED *2/14/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>		DATE THEREOF <i>Feb 14/51</i>		NAME OF CEMETERY OR CREMATORIAL <i>Catholic</i>		LOCATION (City, town, or county) <i>Elkton, Md</i>		(State)	
DATE REC'D BY LOCAL REG. <i>Feb 14</i>		REGISTRAR'S SIGNATURE <i>F K Fraser</i>		24. FUNERAL DIRECTOR		ADDRESS <i>Holy Cross & Son Elkton Md</i>			

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FEB 10 1951

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